

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 110186	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 04/22/2026
NAME OF PROVIDER OR SUPPLIER SHULLSBURG HOME CBRF		STREET ADDRESS, CITY, STATE, ZIP CODE 204 E WATER ST SHULLSBURG, WI 53586		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments On 04/22/2026, the bureau of assisted living southern regional office conducted a verification visit at Shullsburg Home a CBRF located in Shullsburg, WI. As a result of this survey, 0 violations of DHS Chapter 83 were issued. Three of 3 previous violations from statement of deficiency #CJGW11 dated 09/16/2025 were corrected. Under statutory provisions of Wis. Stat. Ch. 50, a \$200 revisit fee is being assessed. Census: 10	{N 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE